# Macular Hole

A macular hole describes a small gap which develops in the macula at the centre of your retina.

A macular hole affects your central vision, making it distorted and blurred so that it’s more difficult for you to do things like read and watch television. You may also have a blank patch in the centre of your vision. However, it doesn’t affect peripheral (side) vision, so doesn’t cause you to lose all your vision in that eye, and it isn’t painful.

## What is the macula?

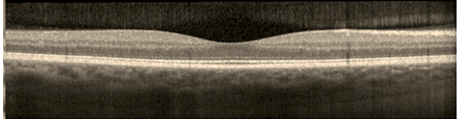
The macula is a tiny area of your retina which is very important for seeing detail, colour and things directly in front of you.

When light enters your eye, it is focused onto your retina at the back of your eye. The retina includes a number of layers, but the most important for vision is a layer made up of cells called photoreceptors. Photoreceptors are cells which are sensitive to light.

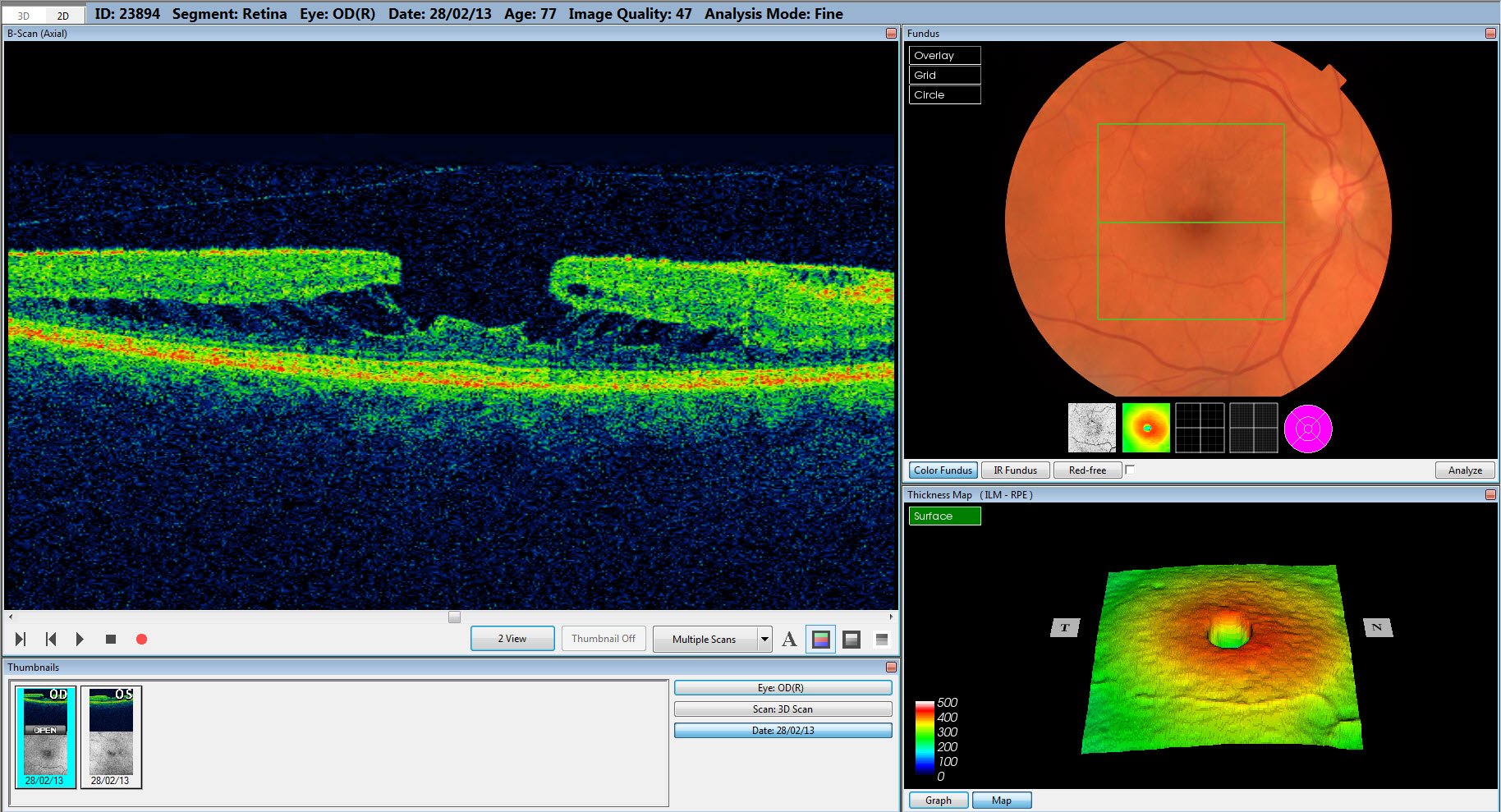
The macula is the tiny central part of your retina, that contains a few million specialised photoreceptor cells called cone cells. These cone cells function best in bright light levels and allow you to see fine detail for activities such as reading and watching television as well as seeing in colour.

Away from the central macula is the peripheral retina, composed mostly of the other type of photoreceptor called rod cells. They allow you to see when light is dim and provide peripheral vision outside of your main line of sight. Peripheral vision is the sight you have out of the corner of your eye when looking straight ahead. A macular hole does not affect your peripheral vision.

Below are scans showing a cross section of the macula. The top scan shows a normal macula and the bottom scan shows a macular hole.



Cross section scan of a normal macula



Cross section of the macula where a macular hole is present

A macular hole is a very different eye condition from macular degeneration, even though they both affect the macula. For this reason, they are treated differently to each other. Macular degeneration causes the cells of the macula to stop working whereas a macular hole is an actual gap in the macular structure. It is possible, however, to have both conditions at the same time. A macular hole is also not the same as a retinal hole and is treated differently.

You can find more information about macular degeneration (AMD) on our website **www.rnib.org.uk/eyehealth** or by calling our Helpline **0303 123 9999** and requesting our information about AMD.

## What causes a macular hole?

Often there is no known reason why someone develops a macular hole. They are more common between the ages of 60 and 80, but it is possible for a macular hole to develop at a much earlier age than this. Women tend to experience them more often than men. Macular hole has also been linked to:

* being slightly long-sighted (slight hyperopia)
* being very short-sighted (high myopia)
* having a severe eye injury
* having had a retinal detachment
* having long lasting macular swelling (cystoid macular oedema)
* your vitreous gel pulling on the macula (vitreomacular traction)

### How does vitreomacular traction cause a macular hole?

Your eye is filled with a clear gel called the vitreous. The vitreous helps to keep your eye’s shape and allow light to pass through to the retina. The vitreous gel inside your eye is attached more firmly to the retina in different places. One of these is the macula. As the vitreous naturally shrinks, becoming more watery and less like a gel with age, it begins to pull away from the retina, including the macula. Usually the vitreous comes away from the back of the eye smoothly without causing any problems or requiring any treatment. This is known as a posterior vitreous detachment or PVD. For some people, the vitreous gel does not detach completely from their retina, remaining strongly attached in some places. If their vitreous gel remains strongly attached at the macula, this may lead to a greater pulling on it. This is known as vitreomacular traction and this can lead to a macular hole developing.

If there is vitreomacular traction present, some people initially notice symptoms of floaters and flashes of light in their vision, even before their central vision gets worse. It‘s important to have symptoms like these checked within 24 hours by visiting an optometrist (also known as your optician) or by attending A&E or eye casualty because, as well as the pulling action of the vitreous gel which can lead to macular hole, floaters and flashes can also be caused by retinal detachment which requires urgent treatment to prevent sight loss.

You can find out more about PVD by looking at our website **www.rnib.org.uk/eyehealth** or by calling our helpline on **0303 123 9999** and requesting our information about PVD.

## How does a macular hole affect vision?

If you develop a macular hole you will probably notice changes in your central vision. These changes may range from only a slight worsening of central vision to a very noticeable decline, depending on the size and depth of your macular hole. As a macular hole develops, your vision will seem blurred and straight lines may look wavy and distorted, so that you have difficulty reading small print for example. You may even notice a small blank patch in the centre of your vision.

There are different stages to the development of a macular hole. These stages (1 to 4) relate to the size and depth of the hole and the extent of vitreous detachment from the retinal surface. If all the layers of the macula structure are involved, it is called a full thickness macular hole. Your ophthalmologist (hospital eye doctor) will identify the stage of your macular hole and advise you about your treatment.

It’s possible that an early stage (stage 1) macular hole will heal itself. Around 50% of stage 1 holes heal without treatment once the vitreous has fully separated from the macula. If your macular hole is at stage 1, your ophthalmologist may want to monitor things for a few months before recommending any treatment.

Most macular holes carry on developing, particularly if they are bigger than stage 1, so that your central vision worsens, becoming more distorted and blurred. In general, the bigger your macular hole is, the more difficult it will be for you to read down the letter chart. Macular hole treatment attempts to close the macular hole and to improve and stabilise your vision as much as possible.

## Will I get a macular hole in my other eye?

Most commonly, macular hole affects only one eye, but it is possible for some people to develop macular hole in their other eye at some point in the future. Unfortunately, there’s nothing you can do to prevent this from happening. Your future risk of a macular hole in your other eye may range from being very unlikely up to around a 1 in 10 (10%) chance. However, your ophthalmologist is the best placed person to advise you what your future risk of this happening might be, having assessed your overall eye health. If you notice your vision is changing in your other eye you should contact your eye clinic or your optometrist as soon as you can so that your eyes can be examined. When you no longer need to attend the hospital eye clinic, it is recommended you continue to visit your optometrist regularly, as they will be able to monitor your eye health over time.

## Can I still drive when I have a macular hole?

Many people with a macular hole are able to carry on driving because it usually only affects their vision in one eye. You’re required by law to tell the Driver and Vehicle Licensing Authority (DVLA) if you have an eye condition which may affect your vision in both eyes. Therefore, you can continue to drive if you only have a macular hole in one eye and your vision in your other eye meets the DVLA driving standard. Your optometrist or ophthalmologist will be able to tell you if your vision meets the DVLA standard and whether you need to let the DVLA know as this may depend on whether you also have any other eye conditions present.

## What treatment is available for macular hole?

If your ophthalmologist feels you need treatment for your macular hole, they may suggest an injection, but, more usually, they will suggest having an operation. Your ophthalmologist will advise you as to the best treatment for you.

### Jetrea (ocriplasmin) injection

Jetrea is given as an injection into the eye. The aim of this treatment is to separate the adhesions between the vitreous and the macula so that the vitreous doesn’t pull on the macula anymore. Jetrea can only be given to people with smaller macular holes and it can cause complications for some people too. However, it is not widely used by ophthalmologists because surgery is a more successful treatment.

If you are offered Jetrea, it is given as a one-off injection into the vitreous gel through the white of your eye (the sclera).

The injection only takes a few seconds to carry out and you’ll have an anaesthetic drop in your eye first, to numb it so that you don’t feel any pain. Afterwards, you’ll be given antibiotic drops to put in your eye for a few days to prevent you getting an infection.

If, after having this injection, you notice a worsening of your vision or symptoms such as redness, pain or blurred vision, it’s important to seek medical attention immediately.

## Surgery for macular hole

Surgery is the usual treatment offered by ophthalmologists and it aims to improve and stabilise your vision by closing the macula hole. The likelihood of this being successful depends on the size of your macular hole and how long you’ve had it. It also depends on whether you have any other eye conditions that may affect the outcome of surgery. Your ophthalmologist is the best placed person to advise you about whether surgery is appropriate for you, what the risks are in your particular case and what they expect the result of your treatment to be. Generally, where surgery is recommended, it is successful in closing around 9 out of 10 macular holes, particularly if it has been present for less than a year.

If the first surgery is not successful in closing your macular hole, your ophthalmologist may suggest re-operating on your eye, depending on your individual circumstances. However, most people don’t need to have a second surgery as a macular hole usually closes the first time.

There are two main stages to the treatment:

* Surgery to remove the vitreous and insert a gas bubble into the eye.
* A recovery period when the gas bubble left inside your eye acts like a bandage, creating an environment that encourages your macular hole to close.

#### When should I have the surgery?

If you have a macular hole, your ophthalmologist will assess whether you would benefit from having surgery or whether they want to monitor your macular hole for a period of time. If your ophthalmologist feels surgery is needed, they usually want to operate sooner rather than later, which could be as early as three to four months for some people. Generally, the longer you’ve had your macular hole, the larger it is likely to be, so surgery may be less successful in improving your vision. However, your ophthalmologist will be able to advise you about the likelihood of success in your case.

#### Will surgery help my vision?

In many cases, surgery can stop your blurred and distorted vision from getting worse and can help your sight to improve. For some people this can be to a high standard. In the months that follow surgery, 80-90% of people have some degree of improvement in their vision, but this can depend on the size and age of the macular hole and what level of vision was present before surgery. Generally, the treatment of smaller and newer macular holes is more likely to give a better improvement in vision. If your macular hole is closed early enough, ideally within a few months of being diagnosed, your vision might improve by two or three lines of letters, sometimes more, on the sight test chart. There have even been some cases where treatment of more longstanding macular holes has led to visual improvement. As the outcome of treatment can vary from person to person, your ophthalmologist will be able to discuss with you how they hope you will benefit from surgery, depending on all aspects of your eye health and the stage of your macular hole.

Even if you’ve had your macular hole for a longer time, it may be still possible to gain some improvement in your vision after treatment, so speak with your ophthalmologist about what they expect the likely outcome of surgery will be for you. Whenever you have your surgery, even if your vision doesn’t improve much, it’s likely to stabilise and give you less distortion. For a minority of people, vision can worsen after surgery which may lead your ophthalmologist to suggest a second operation.

It’s important to realise that macular hole surgery is very unlikely to make your sight completely normal again or as it was before the hole developed. Even after surgery, you may still have some level of distortion remaining or a small, missing patch in your vision.

It can take several months after surgery for the eye to fully recover and for someone to know just how much vision they have re-gained. Most of the eye recovery and vision improvement occurs within the first three months after surgery.

#### What happens if I don’t have the surgery?

If you don’t have treatment for your macular hole, your central vision is likely to continue to get worse in that eye. Only a small number of macular holes close up on their own, usually when they are much smaller in size. This will mean that you have difficulty seeing detail with that eye, possibly being unable to read the largest letters on the sight test chart. However, a macular hole does not affect your peripheral vision so you wouldn’t lose all your sight in that eye if you didn’t have surgery. Depending on how much your vision is affected by your macular hole, you may experience some difficulties with certain tasks at work or at home or with hobbies and sports. This may be because your ability to see detail in that eye is reduced or because you’re struggling with depth perception. This could include tasks like judging steps or correctly gauging how to pour liquid into a cup, for example. If your macular hole has reduced your central vision in one eye significantly, you may feel like you’re only seeing with your other eye (known as monocular vision).

You can find out more about adapting to monocular vision by looking at our website **www.rnib.org.uk/eyehealth** or by calling our helpline on **0303 123 9999** and requesting our information about monocular vision.

#### What is involved in the surgery?

The operation can take about an hour and would usually be performed under local anaesthetic where an injection numbs the eye so that you don’t feel any pain. If you have a local anaesthetic, you’ll be awake, so you’ll be aware of a cloth drape over your face and of a light above you but it’s unlikely you’ll be able to see any detail of what’s happening. You should ask your ophthalmologist to explain the procedure to you and if you have any concerns about having a local anaesthetic, you should tell them before you have your surgery. It may be possible to have a sedative if you’re anxious about having the procedure under local anaesthetic, but this may not be offered to you routinely unless you ask about it. A general anaesthetic may be offered if you feel unable to have the surgery while you’re awake.

Using fine instruments, your ophthalmologist removes the vitreous gel from the middle of your eye. They take particular care peeling the vitreous and a very thin membrane away from the macular area of your retina. This stops the vitreous from pulling on your macula and allows the hole to close. Removing the vitreous leaves a space inside the eye into which a gas bubble is inserted.

The gas is inserted to help the macular hole heal. This gas is lighter than air, so it floats upwards. The gas bubble sits against the macula providing an environment that encourages it to close and heal. It also helps to protect against the risk of further damage or retinal detachment.

#### After the surgery

In the days after your surgery, to ensure the gas bubble can do its job, you may be asked to position your head in such a way that allows the gas bubble and your macular hole to be in contact for most of the time. This usually means that you’re advised to be in a face down position. This part of the process is known as **“positioning**” (also known as “**posturing**”). Not everyone is asked to position their head in the same way or to the same extent after their surgery. Positioning is described in more detail later on in this leaflet.

Immediately after your surgery, your vision will be very blurred, a bit like trying to see under water. This is caused by the gas bubble in your eye. You may find your balance is affected and that you have less depth perception, so you might misjudge steps and kerbs. You may have difficulty picking things up accurately or pouring out liquids safely. Here are a few ideas that you may find useful to incorporate into things you do every day while the gas bubble is in your eye.

* When putting a drink down, place the other hand on the table or surface, then place the drink next to it.
* When pouring liquid, gently rest the lip of the container on the rim of the cup or glass.
* It can be difficult to judge the last step on the staircase. Move cautiously, feel ahead with your foot and keep a hand on the banister or handrail.
* You may find it useful when crossing the road, to stop at the kerb for a while to gauge the depth of the kerb and the distance of vehicles before crossing.
* You may find you have to turn your head more to see things more clearly towards your affected side.

Over the weeks that follow your surgery, the gas bubble slowly gets smaller and eventually disappears and your level of binocular (3D) vision slowly returns. This process can take from two to twelve weeks depending on the type of gas that was used. Your ophthalmologist will be able to advise you about this. As the bubble shrinks, you’ll notice a line across your vision, which wobbles as you move, like a spirit level. This line will gradually continue to edge downwards as the gas bubble gets smaller and you’ll be able to see above the line, while your vision below the line will remain blurred. Finally, the bubble becomes tiny before disappearing altogether.

As the gas bubble shrinks, the space that it took up fills with aqueous fluid, so you’ll not be left with an empty space in the middle of your eye. Aqueous fluid is a natural fluid made inside your eye and once it has completely replaced the bubble, your vision should improve.

While the gas bubble remains in your eye, it can react with another gas, nitrous oxide, which is used in some general anaesthetics and as pain relief in A&E and during childbirth. Nitrous oxide can make the gas bubble in your eye expand, raising your eye pressure, which can damage your sight. You should tell any medical staff treating you that you have gas in your eye and that you shouldn’t be given nitrous oxide. Similarly, if you need a general anaesthetic while you still have gas in your eye, it’s important to tell the anaesthetist before your operation.

### Possible complications after macular hole surgery

In the majority of cases, macular hole surgery has a high success rate, but a successful outcome will also depend on your individual circumstances and other aspects of your eye health. All surgery carries some risk of complications, and within macular hole surgery, if a complication develops, there are treatments available. For this reason, it is rare for someone to lose vision due to complications following macular hole surgery. However, your ophthalmologist will advise you on what the possible complications are and the chances of them happening to you. Complications from macular hole surgery include:

#### Cataract

Almost everyone that has this operation will develop a cataract, usually within a year of having the procedure or possibly sooner. A cataract is a clouding of the natural lens in your eye. As it’s almost certain that you’ll develop it, your ophthalmologist may suggest cataract surgery at the same time as your macular hole surgery. You can ask your consultant beforehand if they plan to remove your lens during your surgery. Even if you don’t have cataract surgery at the same time as your macular hole surgery, you can still have your cataract removed at a later date.

You can find more information about cataract and coping after it is removed on our website **www.rnib.org.uk/eyehealth** or by calling our Helpline **0303 123 9999** and requesting our information about cataract.

##### Raised eye pressure

Following all types of eye surgery there is a risk of raised eye pressure, which is different from blood pressure. Eye pressure will usually go up in the short-term following surgery and you may be given eye drops to reduce it whilst you recover. Eye pressure comes down to a normal level for most people during their recovery, but for some people, eye pressure may become, and possibly remain, too high in the long-term. This can damage the optic nerve at the back of the eye and reduce vision. Raised eye pressure that damages the optic nerve is called glaucoma. If necessary, there are treatments available to control your eye pressure and protect your vision.

You can find more information about glaucoma on our website **www.rnib.org.uk/eyehealth** or by calling our Helpline **0303 123 9999** and requesting our information about glaucoma.

##### Infection

Following all types of eye surgery there’s the risk of getting an eye infection and you’ll be given antibiotic drops after your surgery to help prevent this from happening. Infection occurs in about 1 in 1000 in macular hole procedures, and it can be treated, although, if a serious infection occurs it can lead to sight loss. However, infection is rare.

**Retinal detachment**

When the ophthalmologist peels the jelly from your retina, there’s a small chance that the retina may detach away from the back of your eye. This happens to 1-2% of people (1-2 people out of 100). If this happens, the retina needs to be reattached as soon as possible to prevent you losing your sight.

You can find more information about retinal detachment on our website **www.rnib.org.uk/eyehealth** or by calling our Helpline **0303 123 9999** and requesting our information about retinal detachment.

**Bleeding**

This is a very rare complication of macular hole surgery and can lead to sight loss if the bleeding is severe.

## Positioning face down (posturing) after surgery

The role of positioning face down after macular hole surgery has been debated and the position that is advised after surgery can vary between ophthalmologists. Some people are advised to maintain a face-down position for a period of time following surgery. This is to improve the chances of a better outcome by keeping the floating gas bubble in contact with the macular hole for as long as possible. Although face-down positioning might improve the outcome for larger macular holes, most can be successfully repaired without the need for uncomfortable positioning.

The length of time you’re recommended to maintain a particular head position each day, and for how many days can also vary, but it is usually between three days and a week. Your ophthalmologist can discuss with you what they feel is best in your case and whether you need to position your head face down at all. They would also take into account what they feel you can manage. For example, some people with arthritis or back problems may not be able to position face down for long periods at a time or for as many days.

If you’ve been advised to position face down after your surgery, maintaining this posture can be an important part of your recovery.

Staying face down for a long time can be difficult so it’s important to discuss with your ophthalmologist any other medical problems that may affect your ability to maintain this position. If your ophthalmologist feels you need to position face down, it may be possible to get short term help from social services while you are recovering from the macular hole surgery.

### What does positioning face down involve?

You may be advised to spend 45-50 minutes out of every hour in a face down position. This gives you 10-15 minutes every hour for things like eating, using the bathroom and, importantly, putting in any eye drops you’ve been advised to use after your surgery. Your ophthalmologist will tell you if they recommend that you position face down after your surgery and if so, for how long. It may also be possible to get some tips on how to manage your face down positioning from a nurse in the eye clinic. It is important for you to discuss any particular concerns you might have about maintaining this posture with your ophthalmologist or clinic nurse before the day of your surgery.

It’s not necessary to lie completely flat and many people position face down whilst sitting in a chair and leaning forward onto some sort of support such as another chair or table or using a face cradle, which is a U-shaped pillow on a frame. A U-shaped travel pillow that is usually used for neck support, can also work well as face down support in positioning after surgery.

Your eye clinic staff should be able to advise you about aids that can help you with face down positioning. Trying out differentideas to help with this positioning can help you choose the most comfortable way for you. For example:

* Sitting at a table and leaning forwards onto a face cradle or U-shaped pillow on the table.
* Some people prefer to remain in bed, placing their faces between pillows or a U-shaped pillow which allows you to breathe whilst maintaining a face down position.

It might be useful to have various places to position yourself face down so you may want to try all of them before going into hospital to see which one you prefer. Different positions and changing where you are sitting may help any stiffness or boredom.

### How should I prepare for positioning face down?

If your ophthalmologist wants you to position face down after surgery, you’ll be expected to start doing it straight away when you come home. So, before you go into hospital, it can be useful to plan ahead to prepare your home first.

* Do any housework that is necessary.
* Make sure the things you’re going to use for face down positioning are in the right place.
* Move furniture and pillows into the place where you are going to be positioning face down.
* Make sure that the floor is clear of clutter, to help you get around without falling or having to move anything.
* Organise a shopping trip so that you don’t have to worry about things like food and toiletries.
* You may want to prepare some food in advance that may just need heating up as this will save time on preparing and cooking meals.
* You may want to rely on ready meals just for this period, that only need heating up in the microwave.
* Arrange to pay any bills that are due and to organise any benefits to be collected if you would normally need to do this.

Wherever you position face down, it is a good idea to have things close by that you may need.

* Things like tissues or soft drinks or fruit are good to have close by.
* If you find it difficult to drink and maintain the position, then a straw may help.
* If drinking is still difficult then ice cubes are very good at moistening the mouth without you having to swallow a drink.
* Drinking is important though and should be encouraged on your breaks from positioning face down to avoid dehydration.
* You may also want to have some form of entertainment. It may not be possible to watch TV so having a radio or tablet device close by can help with the boredom, as can listening to music or talking books that you enjoy.
* Move the telephone too, as you will be able to answer it better if it’s near you.

#### How do you position face down when you are sleeping?

You’ll probably be advised not to lie on your back whilst sleeping. Propping pillows on either side of you can help to stop you rolling onto your back. Some people attach objects such as tennis balls onto the backs of their nightwear to stop themselves from rolling onto their backs.

When lying on your front, it can help to pop a pillow under your forehead and another one under your chest and chin to help create a breathing space and make you feel more comfortable. Alternatively, you may prefer to use an upturned V shaped orthopaedic support pillow or make an upturned V shape out of pillows, resting your forehead on the point where they meet and breathing through the space between them.

Some ophthalmologists recommend sleeping in a chair or propped up in bed at a 45 degree angle using the support of pillows, while some are happy for you to sleep on your side.

It can be tricky to keep the right position overnight whilst sleeping and your ophthalmologist can discuss any concerns you have about this with you. As long as you are positioned as you have been advised to do throughout the day and doing what you can to be in the recommended position at night, then you’re doing the best you can to enable your macular hole to heal.

#### Should I have help at home whilst I recover?

If it’s possible, it can help to have someone, such as a family member or friend, to stay with you whilst you are positioning face down. Having someone to make drinks and food can be extremely helpful so that you don’t have to spend any of your time doing these things when you’re not positioning face down. Having someone to help you whilst you recover may be of particular importance if you have sight loss in your other eye or if you have another disability.

For many people it’s not possible to have someone stay with them after surgery. Your hospital may be able to arrange short-term care at home for up to six weeks after surgery. This might involve help with shopping, food preparation, cooking, cleaning, or looking after your personal hygiene. If you feel this kind of help would be of use, then it is important to discuss it with the hospital well in advance of your surgery date, so they have time to make the appropriate care arrangements for you. The RNIB Helpline can provide you with further advice about help and care services that are available.

### What eye drops will I need after surgery?

Immediately after the surgery you’ll probably be given eye drops, which usually include an antibiotic drop to prevent infection, a steroid drop to help reduce any swelling and possibly a mydriatic drop that widens (dilates) your pupil to minimise movement of your iris (coloured part of your eye), as this movement can make your eye uncomfortable after surgery. You might also be asked to use an eye drop to help control your eye pressure if it remains raised after your surgery. It’s important to use these drops exactly as your ophthalmologist recommends and to complete the course. Your eye clinic should be able to give you information on how to use your eye drops. If you have problems using the drops, you should let your GP know as they may be able to arrange some help for you.

You should let the hospital know straight away if, after surgery, your eye becomes painful, increasingly hot or red, you become more sensitive to light, your vision suddenly gets worse, you notice new or increased symptoms such as floaters or flashes of light in your vision, or you develop a headache, as these symptoms can be signs of possible side effects.

### What activities can I do after surgery?

After surgery, you can usually go back to your general everyday activities once you have finished positioning face down. However, most people are advised not to return to work for at least a couple of weeks after surgery. Your ophthalmologist is best placed to advise you exactly how long to take off in your case. This will depend on the type of work you do and also on how you recover. You may also need to avoid the following activities for the first few weeks, or as advised by your ophthalmologist, after surgery.

* rubbing your eye. You may be asked to wear an eye patch or shield when you are sleeping to protect your eye.
* swimming, to avoid infection from the water while your eye is healing.
* strenuous exercise, contact sports and heavy lifting. Everyday lifting like light shopping is usually fine, but heavy lifting like moving furniture is best avoided.
* wearing eye makeup until the hospital are happy for you to do so.
* **you must not fly** **or travel to high altitude on land** until your gas bubble has fully absorbed, which can take up to 12 weeks. The gas bubble expands at high altitude, causing very high pressure in your eye which can cause permanent sight loss.
* It is unlikely that your vision will be good enough for you to safely drive while you have a gas bubble in your eye. Whilst you are legally entitled to drive if the vision in your other eye is good enough to meet the driving standard, many ophthalmologists think that it’s unwise to do so whilst the bubble remains in your eye. Ask your ophthalmologist for advice about driving after your surgery.

You also need to take extra care:

* when it’s windy or dusty outdoors, in case something blows into your eye, although you don't need to stay indoors. Wearing sunglasses or your usual glasses can help to protect your eyes.
* washing your hair and face. Avoid getting soapy, dirty water in your eye.

As well as a more immediate check-up within a day or so of surgery, you will usually see your ophthalmologist about two or three weeks after the operation to check that your macular hole is healing. At this appointment, you can ask about returning to all your usual activities, including your work, depending on how your eye is recovering. After this, your eye will be checked again after around three months.

### Will I need to get my glasses changed?

Most people will need to change their glasses at some point after their operation, usually when the gas bubble has completely gone about three months after surgery. Your ophthalmologist will be able to advise you as to when you can visit your optometrist for a new glasses prescription.

### Can I do anything to avoid or improve a macular hole?

There is nothing you can do to avoid getting a macular hole and it doesn’t develop because of anything you’ve done. Your diet and exercise haven’t been found to make macular hole more likely. Having an eye examination at least every one to two years, as advised by your optometrist, is the best way to make sure your eyes are healthy and that no new eye conditions are developing. There is nothing you can do to fix a macular hole yourself and, in most cases, treatment is required as recommended by your ophthalmologist.

## What can be done if my sight is seriously affected?

It is uncommon to have a macular hole in both eyes, so even if the operation is not very successful, many people still have good vision in their other eye. Your ophthalmologist would be able to tell you more about your risk of developing a macular hole in your other eye.

If, after surgery, your vision is still affected, then much can be done to make the most of your remaining vision and adapt to any changes.

If both your eyes have been affected, or if the affected eye was your good eye and you have a sight problem in your other eye, then you may need to make changes or use aids to make the most of your remaining sight. This may mean making things bigger, using brighter lighting or using colour to make things easier to see. We have a series of leaflets with helpful information on living with sight loss, including how to make the most of your sight. You can find out more about our range of titles by calling our Helpline on **0303 123 9999**.

You should ask your ophthalmologist, optometrist or GP about low vision aids and about having a low vision assessment, where you’ll be able to discuss the use of magnifiers and aids to help you to see things more clearly. However, most people only have macular hole in one eye and have useful vision in their other eye which can help to compensate.

If you also have reduced vision in your other eye due to an eye condition, you should ask your ophthalmologist whether you’re eligible to register as sight impaired (partially sighted) or severely sight impaired (blind). Registration can act as a passport to expert help and sometimes to financial concessions. Even if you aren’t registered, a lot of this support is still available to you.

Local social services should also be able to offer you information on staying safe in your home and getting out and about safely. They should also be able to offer you some practical mobility training to give you more confidence when you are out.

If you have sight changes, you may be worried about finding work, or staying in your job. Our Employment Team can provide specialist support and advice about employment for people with sight loss. You can contact this team via our Helpline on **0303 123 9999**.

## Coping

It’s completely natural to be upset when you’ve been diagnosed with a macular hole and it’s normal to find yourself worrying about the future of your sight.

It can sometimes be helpful to talk about these feelings with someone outside your circle of friends or family. At RNIB, we can help with our telephone Helpline and our Counselling and Well-being Team. Your GP or social worker may also find a counsellor for you if your feel this might help.

You may think of further questions about your eye condition on your way home from hospital or in the days and weeks following your diagnosis. There is someone to turn to with these questions. Your eye clinic may have a sight loss advisor working alongside the doctors and nursing staff. This advisor may be known as either the Eye Clinic Liaison Officer (ECLO), the Vision Support Officer or the Early Intervention Support Officer and they are on hand within your hospital to provide you with further practical and emotional support about your macular hole. Alternatively, you can call our Helpline to speak to our advisors within our Eye Health Team who would be happy to discuss any questions you may have.

## Further help and support

If you have questions about anything you’ve read in this factsheet, or just want to speak to someone about your macular hole, please get in touch with us. We’re here to support you at every step.

Our Helpline is your direct line to the support, advice and services you need. Whether you want to know more about your eye condition, buy a product from our shop, join our library, find out about possible benefit entitlements, or be put in touch with a trained counsellor, we’re only a call away.

It’s also a way for you to join RNIB Connect, our community for anyone affected by sight loss. RNIB Connect is free to join and you’ll have the chance to meet other people with similar experiences in our helpful, welcoming and supportive community.

Give us a call today to find out how we can help you.

**RNIB Helpline**

**0303 123 9999**

**helpline@rnib.org.uk**

We’re ready to answer your call Monday to Friday 8am to 8pm and Saturday 9.30am to 1pm.

You can also get in touch by post or by visiting our website:

**RNIB**

105 Judd Street

London WC1H 9NE

**rnib.org.uk**

### Other useful contacts

**The Macular Society** supports people affected by macula problems. They can be contacted at:

Helpline: **0300 3030 111**

Email: **info@macularsociety.org**

**BEAVRS (British and Irish Vitreo-Retinal Surgeons**) promote high quality patient care by supporting and representing British and Irish Vitreo-Retinal Surgeons through education, research, audit and revalidation. You can find their information on Macular Hole at the following link: **beavrs.org/macular-hole**

## Positioning (Posturing) equipment

RNIB is aware of two companies in the UK who rent equipment which may help some people with face down posturing. They can be contacted at:

**The Massage Table Store (search in their vitrectomy units section for their full range of hire options)**

Pavilion Drive   
Holford Way   
Holford Park   
Birmingham   
B6 7BB

Telephone: **0345 201 0825** or call the office directly on **01827 318236**

Email: [**sales@massagetablestore.com**](mailto:sales@massagetablestore.com)   
Website: **www.massagetablestore.com**

Or

**Face Down Support Hire**

Telephone: **0845 017 0533** or **07957 370635**

Email: **hello@facedownsupporthire.com**

Website: [**www.facedownsupporthire.com**](http://www.facedownsupporthire.com)

## We value your feedback

You can help us improve our information by letting us know what you think about it. Is this factsheet useful, easy to read and detailed enough – or could we improve it?

Send your comments to us by emailing us at [**eyehealth@rnib.org.uk**](mailto:eyehealth@rnib.org.uk) or by writing to the Eye Health Information Service, RNIB, 105 Judd Street, London, WC1H 9NE.

This factsheet has been written by the RNIB Eye Health Information service. Our factsheets have been produced with the assistance of patient and carer input and up-to-date reliable sources of evidence. The accuracy of medical information has been checked by medical specialists. If you would like a list of references for any of our factsheets, please contact us at **eyehealth@rnib.org.uk**.

All of our factsheets are available in a range of formats including print, audio and braille.

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